ENAC
ENTE NAZIONALE PER L'AVIAZIONE CIVILE

APPLICATION FORM FOR AVIATION MEDICAL CERTIFICATE

COMPLETE THIS PAGE FULLY AND IN BLOCK CAPITALS – REFER TO INSTRUCTIONS PAGES FOR COMPLETION

Medical in Confidence

(1) State of licence issue:	(2) Medical certificate applied for 1 ☐ 2 ☐ LAPL ☐ 3 ATC/FIS ☐
(3) Surname:	(4) Previous surname(s):
(5) Forename(s):	(6) Date of birth: (7) Sex : ☐ Male ☐ Female
(8) Place and Country of birth:	(9) Nationality:
(10) Permanent address: Country: Mobile No.: Telephone No.: E-Mail:	(11) Postal address (if different): Country: Telephone No.:
(18) Licence(s) held (type): Licence number: Country:	
(20) Have you ever had an aviation medical certificate denied, suspended or revoked by any licensing Authority? ☐ No ☐ Yes Date: Country: Details:	
(24) Any aircraft accident or reported incident since last medical? ☐ No ☐ Yes Date: Place: Details:	
(27) Do you drink alcohol ? ☐No ☐Yes, amount:	
(28) Do you currently use any medication? ☐ No ☐ Yes State medication, dose, date started and why:	

(12) Application: ☐ Initial ☐ Revalidation/Renewal	
(13) Reference number	
(14) Type of licence applied for:	
(15) Occupation (principal):	
(16) Employer:	
(17) Last medical examination: Date: Place:	
(19) Any limitations on the licence(s)/ medical certificate held: ☐ No ☐ Yes Details:	
(21) Flight time total:	(22) Flight time since last medical:
(23) Aircraft class/type presently flown:	
(25) Type of flying intended:	
(26) Present flying activity: ☐ Single pilot ☐ Multi Pilot	
(29) Do you smoke tobacco? ☐ No,Never ☐ No,date stopped: ☐ Yes, state type and amount:	

General and medical history:Do you have, or have you ever had, any of the following? (Please tick). If yes, give details in remark section (30).

	Yes	No		Yes	No		Yes	No		Yes	No
(101) Eye trouble/eye operation	☐	☐	(112) Nose, throat or speech disorder	☐	☐	(123) Malaria or other tropical disease	☐	☐	**Females only:**		
(102) Spectacles and/or contact lenses ever worn	☐	☐	(113) Head injury or concussion	☐	☐	(124) A positive HIV test	☐	☐	(150) Gynaecological, menstrual problems	☐	☐
(103) Spectacles/ contact lens prescriptions change since last medical exam	☐	☐	(114) Frequent or severe headaches	☐	☐	(125) Sexually transmitted disease	☐	☐	(151) Are you pregnant?	☐	☐
(104) Hay fever, other allergy	☐	☐	(115) Dizziness or fainting spells	☐	☐	(126) Sleep disorder/apnoea syndrome	☐	☐	**Family history of**:		
(105) Asthma, lung disease	☐	☐	(116) Unconsciousness for any reason	☐	☐	(127) Musculoskeletal illness/impairment	☐	☐	(170) Heart disease	☐	☐
						(128) Any other illness or injury	☐	☐	(171) High blood pressure	☐	☐
(106) Heart or vascular trouble	☐	☐	(117) Neurological disorders: stroke, epilepsy, seizure, paralysis etc.	☐	☐	(129) Admission to hospital	☐	☐	(172) High cholesterol level	☐	☐
(107) High or low blood pressure	☐	☐	(118) Psychological/psychiatric trouble of any sort	☐	☐	(130) Visit to medical practitioner since last medical examination	☐	☐	(173) Epilepsy	☐	☐
(108) Kidney stone or blood in urine	☐	☐	(119) Alcohol/drug/substance abuse	☐	☐	(131) Refusal of life insurance	☐	☐	(174) Mental illness	☐	☐
(109) Diabetes, hormone disorder	☐	☐	(120) Attempted suicide	☐	☐	(132) Refusal of flying licence	☐	☐	(175) Diabetes	☐	☐
(110) Stomach, liver or intestinal trouble	☐	☐	(121) Motion sickness requiring medication	☐	☐	(133) Medical rejection from or for military service	☐	☐	(176) Tuberculosis	☐	☐
(111) Deafness, ear disorder	☐	☐	(122) Anaemia / sickle cell trait/ other blood disorders	☐	☐	(134) Award of pension or compensation for injury or illness	☐	☐	(177) Allergy/asthma/eczema	☐	☐
									(178) Inherited disorders	☐	☐
									(179) Glaucoma	☐	☐

(30) **Remarks**: If previously reported and no change since, so state.

(31) Declaration: I hereby declare that I have carefully considered the statements made above and to the best of my belief they are complete and correct and that I have not withheld any relevant information or made any misleading statement. I understand that if I have made any false or misleading statement in connection with this application, or fail to release the supporting medical information, the licensing authority may refuse to grant me a medical certificate or may withdraw any medical certificate granted, without prejudice to any other action applicable under national law.

Consent to release of medical information: I hereby authorize the release of all information contained in this report and any or all attachments to the AME and, where necessary, to the medical assessor of the licensing authority, recognizing that these documents or electronically stored data are to be used for completion of a medical assessment and will become and remain the property of the licensing authority, providing that I or my physician may have access to them according to national law. Medical Confidentiality will be respected at all times.

Date	Signature of applicant	Signature of AME/Medical assessor
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